Letters to the editor

BENZODIAZEPINES RISK, ABUSE, AND DEPENDENCE: A TSUNAMI IN A TEA CUP

DEAR EDITOR:

In response to a letter to the editor published in the November issue of *Psychiatry 2009* [Preparing for a Benzodiazepine Tsunami. *Psychiatry* (Edgemont) 2009;6(11):12], Dr. Prabhakar warns the psychiatric professional community about the risk of a proposed change in the Medicare prescription plan through which benzodiazepines will be reinstated after several years of being excluded from coverage in their formularies. He is concerned that this will result in a "tsunami" of benzodiazepine abuse and "other side effects" associated with these medications.

We found Dr. Prabhakar's comments troubling in several respects.

Dr. Prabhakar expresses his alarm at and disapproval of provisions in Section 175 of the Medicare Improvements for Patients and Providers Act of 2008. He would like to see benzodiazepine prescription coverage denied to those on Medicare as occurred in the Prescription Drug, Improvement and Modernization Act (MMA) of 2003 and in effect since 2006. In support of this, he cherry picks evidence to support his position (even when it does not). He fails to cite a larger body of contrary evidence on several points and misrepresents evidence several times.

For example, he cites a 2001 article by van Haaren, Lapane, and Hughes as a source of evidence that "in many cases benzodiazepines were overprescribed." In fact, this paper does not provide evidence that benzodiazepines were overprescribed. Van Haaren concluded that the triplicate prescription policy "did affect prescription and administration of benzodiazepines in nursing homes in states with, versus without, a triplicate prescription policy. Lack of substitution with other drugs makes it unclear whether overprescribing occurred in states without a policy, or undertreatment occurred in the state with a policy." Such a study of nursing home residents is hardly a reliable reflection of over-prescription of benzodiazepines in the general population.

Dr. Prabhakar states that "several studies failed to demonstrate any rise in the use of other psychotropic medications after MMA was enacted." Yet he fails to give a single citation on this point. In fact, several studies clearly provide evidence that the New York state triplicate prescription policy did result in the increased use of older, more dangerous sedative-hypnotics, such as barbiturates and meprobamate, and an increase in prescriptions for benzodiazepines in the neighboring state of New Jersey in the years following this policy.[1–3]

Dr. Prabhakar mentions the increased risk of falls in elderly on benzodiazepines and cites a 2007 article by Wagner et al to report that the MMA "resulted in about 50 to 60 percent reduction in benzodiazepine use." However, he fails to mention that the same Wagner et al study concluded that "policies that lead to substantial reduction in the use of benzodiazepines among elderly persons do not necessarily lead to decreased incidence of hip fractures. Limitations on coverage of benzodiazepines under Medicare Part D may not achieve this widely assumed clinical benefit."

While benzodiazepine substance dependence and abuse can occur, the overwhelming weight of epidemiological evidence[4] suggests that this is a problem only for a very small minority of patients (0.6% for abuse and 0.5% for dependence among users) and that the rates of abuse of benzodiazepines are significantly lower than the rates of abuse of food.

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The US Food and Drug Administration (FDA) approves medications as safe and effective for specific indications. They do post-marketing surveillance on benzodiazepines and other

psychiatric medications. If the FDA thought that benzodiazepines were not safe or effective or that the risk-to-benefit ratio was unfavorable they would intervene with appropriate warnings. Benzodiazepines do not have a black box warning, like all antidepressants, all atypical and typical neuroleptics, and anticonvulsants. They are effective where indicated. They do have a significant withdrawal syndrome that needs to be managed properly. All physicians need to taper benzodiazepines very slowly over weeks rather than over days to minimize this risk.

We do not need medical vigilantes policing physician prescribing practices with policies that are at variance with the FDA prescribing information guidelines and are based on cherry-picked data and self-righteous prejudices and threats of loss of prescribing privileges.

To deliberately and selectively deprive people over 65 of benzodiazepines, as Dr. Prabhakar advocates, could be considered age discrimination in violation of the Civil Rights Act of 1964. Medicare for those over 65 is a right rather than a privilege. To further deprive some of those under 65 on Medicare who have disabilities and impairment from conditions that would benefit from a benzodiazepine would be a violation of the American Disabilities Act. Physicians and even medical vigilantes would prefer not to be on the wrong side of such legal action.

In summary,we recommend that medical authors proposing overzealous action learn to evaluate evidence in a balanced manner, not misquote the authors they cite and not cite evidence that does not exist.

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AUTHOR RESPONSE

Thank you to Drs. Hidalgo and Sheehan for commenting on my letter to the editor from the November issue of *Psychiatry 2009*.

The authors contend that I am concerned about the "tsunami of benzodiazepine abuse and other side effects." However, the point I make is that in response to implementation of the Medicare Improvements for Patients and Providers Act of 2008 [MIPPA], we will, most likely, observe a surge in benzodiazepine prescriptions and "use." If we implement careful patient-selection strategies based on sound clinical judgment and existing evidence-based guidelines[1] there is no reason to be alarmed that we will also observe a surge in benzodiazepine-related adverse outcomes. The authors assert that I cherry picked the evidence notwithstanding that I clearly state, "There is a general consensus on the benefits that benzodiazepine offer in a variety of psychiatric and nonpsychiatric conditions." The authors question the citation of van Haaren et al[2] study in my article. van Haaren et al clearly state, "In the absence of benzodiazepine therapy, we found no corresponding increase in administration of other drugs that might replace benzodiazepines." They further state, "One explanation for these findings is that the triplicate prescription policy removed only the unnecessary administration of benzodiazepines in nursing homes." To mention this as a hypothesis does not amount to "misrepresentation of evidence." I did not cite Wagner et al[3] to implicate benzodiazepines in increased risk of falls among elderly. I did cite Wagner et al[3] in order to point out reduction in benzodiazepine use as a result of increased overseeing by states. The authors assume my "alarm and disapproval" of provisions in Section 175 of the MIPPA and that I would "like to see benzodiazepine

prescription coverage denied to those on Medicare." The authors also assert that I advocate for denying benzodiazepines to people under age 65. The fact is that I wholeheartedly support provisions in Section 175 of the MIPPA. At no point in my letter did I make a case for exclusion of benzodiazepines for those on Medicare or for people under age 65. However, I do make a case for self monitoring within our profession that would preclude a need for any blanket exclusion law, such as Medicare Prescription Drug, Improvement, and Modernization Act [MMA] in future. It's regrettable that some would see this as a "threat of loss of prescribing privileges." The idea is to make sure that clinical judgment of treating physicians in conjunction with informed consumer preferences is held paramount while prescribing benzodiazepines independent of demographics or insurance status of consumers. In this context it is important to remember that if there were no concerns about the use of benzodiazepines in the vulnerable elderly population, this class of medications would not have been restricted by the MMA in the first place.

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